

TAB 18

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UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

Civil Action No.: 04-11939-JGD

MICHAEL J. WHALON,
Plaintiff,

v.

CHRISTY'S OF CAPE COD, LLC,
Defendant.

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DEPOSITION of **ETHAN H. KISCH, M.D.**, a witness called
on behalf of the Defendant, taken pursuant to the
applicable provisions of the Massachusetts Rules of
Civil procedure, before John F. Kielty, a Notary
Public in and for the Commonwealth of Massachusetts,
at the offices of Quality Behavioral Health, 1090
New London Avenue, Cranston, Rhode Island, on
Friday, May 5, 2006, commencing at 10:03 a.m.

JOHN F. KIELTY
2 Garrett Place
Plymouth, Massachusetts 02360
(508) 759-6767

1 another --

2 A. My understanding is because of my experience
3 in treating people with bipolar disorder. I've had
4 other referrals from clinical nurse specialists for
5 that type of treatment in Massachusetts and Rhode
6 Island.

7 Q. Now, I would note that the records that you
8 have produced to me to date are all from behavioral
9 health, which is the --

10 A. Quality Behavioral Health.

11 Q. I'm sorry.

12 A. Right.

13 Q. Quality Behavioral Health, and see --

14 A. This office you are in right now.

15 Q. This office we are sitting in in Cranston,
16 Rhode Island. Are there records that relate back to
17 your treatment or your visits with Mr. Whalon at
18 Arbour in Fall River?

19 A. Yes, those records would be located at
20 Arbour Counseling, or they're probably archived by
21 now would be my guess, and they are not available to
22 me right now.

23 Q. Do you remember the date when you first
24 started working with Mr. Whalon at Arbour?

1 A. I do not, but I would guess it was probably
2 a year or two before he first saw me here.

3 Q. And to your knowledge, did Mr. Whalon see
4 you continuously once he started at Arbour? Did he
5 follow you to this practice?

6 A. Well, as I explained to you, I haven't seen
7 him very frequently, because his primary treater is
8 the advanced practice clinical nurse specialist. I
9 believe he may have had some psychopharmacology
10 consultation with another physician in the Brockton
11 area, and there was a gap in time between his last
12 visit with me at Arbour Counseling and his first
13 visit with me here May 4, 2005.

14 Q. And do you know how long that gap in time
15 was?

16 A. I don't know, because I don't know the dates
17 when he saw me at Arbour. But I would guess that it
18 might have been between six months to a year,
19 possibly a little longer.

20 Q. Do you know the identity of this other
21 psychopharmacologist that he may have seen in the
22 interim?

23 A. Oh, let's see. I don't believe I have that
24 in the record here, and I'm not remembering offhand

1 Q. Very good. I may well already have that
2 name.

3 A. Okay.

4 Q. I just wanted to ask you. And have you
5 referred Mr. Whalon to anyone else?

6 A. No.

7 Q. And is it correct that the services you
8 provided to Mr. Whalon were individual in nature, in
9 other words, no family counseling, marital
10 counseling, any of those types of services?

11 A. That's correct. He came on his own.

12 Q. Now, can you for my enlightenment describe
13 for me the type of care that you have provided for
14 Mr. Whalon?

15 A. As I've already stated, I provided
16 psychopharmacology consultation and treatment. So
17 consultation to his primary provider, Anne
18 Kronenberg, and treatment just in regard to the
19 prescriptions that I myself have written.

20 Q. Have you provided any psychotherapy for Mr.
21 Whalon?

22 A. No.

23 Q. And is it your understanding that he is
24 receiving psychotherapy with Ms. Kronenberg?

1 A. I believe he is.

2 Q. The records that you produced to me from
3 Quality Behavioral Health reflect three visits, --

4 A. Yes.

5 Q. -- I believe? And as you sit here today,
6 is that your recollection, that you saw him for
7 those three visits?

8 A. That is correct.

9 Q. How long would these visits last?

10 A. Probably his first appointment here with me
11 might have been a little bit longer, maybe 45
12 minutes to an hour. The subsequent two visits were
13 probably 20 to 30 minutes.

14 Q. I may have asked you this in another way,
15 but just so I am clear, have you spoken with anyone
16 other than Anne Kronenberg and today, obviously,
17 regarding your treatment of Mr. Whalon?

18 A. I have not.

19 Q. And other than the records that you are
20 indicating may be maintained by Arbour Counseling in
21 Fall River, are you aware of any other records
22 relating to Mr. Whalon, whether they are yours or
23 any other --

24 A. Well, I --

1 far as I know during the period in which I've
2 treated him.

3 Q. And that is all I am trying to ask you,
4 Doctor.

5 A. Yeah.

6 Q. I am not looking for you to commit beyond
7 what you would know.

8 A. Yeah, he may have had a hospitalization at
9 some point in the past, but I'm not recalling it if
10 he did.

11 Q. Now, for what conditions have you treated
12 Mr. Whalon?

13 A. For bipolar disorder condition.

14 Q. For any other conditions --

15 A. No.

16 Q. -- besides bipolar disorder? Are you aware
17 of any other mental health conditions that Mr.
18 Whalon suffers from or has suffered from?

19 A. Well, patients with bipolar disorder
20 frequently have many comorbid conditions, including
21 anxiety disorders.

22 And I see in my notes from July 19, 2005
23 that he had anxiety symptoms which responded to
24 Quetiapine. That's the Seroquel that I had

1 previously recommended for manic symptoms. So
2 the -- but I would say that the other -- the other
3 diagnosable psychiatric disorders were really
4 comorbid to bipolar disorder, which is his primary
5 condition.

6 Q. Did you ever treat Mr. Whalon for obsessive
7 compulsive disorder?

8 A. Not per se.

9 Q. When you say "not per se," --

10 A. Not as such. That was not a primary
11 diagnosis for which I was treating him.

12 Q. Would I be correct in understanding that
13 there may be some shared symptoms between obsessive
14 compulsive disorder and bipolar --

15 A. Yes.

16 Q. -- disorder?

17 A. In fact, the research in bipolar disorder
18 shows that patients with bipolar disorder are more
19 likely than patients with so-called unipolar major
20 depression to have certain anxiety disorders,
21 actually, twice the prevalence rates for bipolar
22 patients compared to unipolar patients, specifically
23 for excessive compulsive disorder and also for panic
24 attacks and some indications that other anxiety

1 disorders may also be more prevalent for bipolar
2 patients, and also bipolar patients, youth and
3 adults, are more likely than unipolar patients to
4 have multiple anxiety disorders.

5 THE REPORTER: Could I have a second,
6 please, Tom?

7 MR. COLOMB: Sure.

8 (Discussion off the record.)

9 BY MR. COLOMB:

10 Q. Are you aware of any other -- first, any
11 other mental health conditions that Mr. Whalon
12 suffers from apart from bipolar disorder?

13 A. I am not.

14 Q. Are you aware of any other medical
15 conditions that Mr. Whalon suffers from apart from
16 bipolar disorder?

17 A. One second. He has hypothyroidism, which is
18 probably attributable to Lithium treatment. So
19 Lithium is known to alter thyroid function tests,
20 and, in fact, there is a prescription copy in his
21 record for Levothyroxine from me.

22 Q. What is the significance of that?

23 A. Levothyroxine is thyroid hormone supplement,
24 so that's to correct the hypothyroidism that I

1 believe be to associated with Lithium treatment.

2 But, otherwise, I believe he's medically well.

3 Q. Did you ever treat Mr. Whalon for any
4 substance abuse issues?

5 A. I did not, and I don't believe that he has a
6 substance abuse disorder, at least I don't see that
7 in this record here. And since I don't have access
8 to the Arbour Counseling record, I don't remember
9 that was an issue for him at some time in the past.
10 It's certainly quite possible that he did have a
11 substance abuse disorder, because, again, the
12 research shows that there's nearly two-thirds of
13 adult bipolar patients have a lifetime history of
14 substance abuse disorder. So if he had substance
15 abuse in the past or if he were to develop substance
16 abuse at some point in his lifetime, that's more or
17 less expectable.

18 Q. Is that because individuals of bipolar
19 disorder will attempt to self-medicate their
20 condition or their symptoms?

21 A. Well, that's one --

22 MR. SCOTT: Objection.

23 You may answer. I am objecting to his
24 question, but you may answer.

1 treating him.

2 Q. During the course of treating Mr. Whalon, do
3 you know if he received medication from another
4 source, if he was prescribed medication by another
5 clinician?

6 A. Well, certainly from Anne Kronenberg, and I
7 believe that he had a prescription from the
8 physician in the Brockton area.

9 Q. And you did not object to that taking place?

10 A. Well, in fact, the Olanzapine/Fluoxetine
11 combination I thought was an injudicious medication.
12 So that when I saw him here for the first time, the
13 first thing I did was to have him discontinue that
14 medication.

15 Q. Do you continue to treat Mr. Whalon?

16 A. Actually, I don't know whether he has any
17 follow-up appointments scheduled with me or not.

18 Q. And in reviewing the records that you
19 provided from Quality Behavioral Health, it appears
20 that the last visit in the record was December 1st?

21 A. December 1st.

22 Q. Of 2005?

23 A. That's correct.

24 Q. And have you seen Mr. Whalon since that

1 date?

2 A. I have not.

3 Q. Do you have a standard protocol for office
4 visits with patients like Mr. Whalon?

5 A. If I'm treating them myself, I like to see
6 patients usually every two months. If patients are
7 very stable and I believe reasonably compliant with
8 medication, then I might see them less frequently,
9 every three to six months. For patients who are
10 unstable, high risk of hospitalization, patients who
11 have suicidality or other risk factors, I would see
12 them more frequently.

13 Q. And which of these do --

14 A. Try to do once a month for those people.

15 Q. In which of these three categories did Mr.
16 Whalon fall?

17 A. Well, to the best of my knowledge, he hasn't
18 been hospitalized or certainly not recently, as of
19 12/05.

20 Q. Right.

21 A. So he's -- so he's relatively stable, but I
22 think he -- as you can see from the notes in his
23 record, he is still symptomatic. If I were treating
24 him myself, I would probably put him in the every

1 Dilaudid Rx for muscle pain," also Cyclobenzaprine,
2 which is brand name Flexeril. He complains of
3 persistent irritability, sees -- I meant to say,
4 sees himself as -- oh, no. I'm sorry. He sees the
5 irritability as problematic, potentially affecting
6 occupational functioning, and then the notation
7 that I just read to you about lab work from July
8 '05.

9 Q. Do you have any recollection of discussing
10 employment with Mr. Whalon during this December
11 visit?

12 A. Not beyond what I have notated here.

13 Q. As you sit here today, do you have any
14 knowledge of what Mr. Whalon does for employment?

15 A. I don't know actually.

16 Q. Okay.

17 A. And I would be hard pressed to say what the
18 litigation with Christy's is about.

19 Q. The statement, no major occupational
20 difficulties, do you know if that was in response to
21 a question you asked?

22 A. Yes.

23 Q. Okay.

24 A. It would have been.

1 Q. Is that because that is a typical question
2 you would ask?

3 A. Yes, but also, because he had told me when I
4 saw him for the first time after an interruption in
5 treatment in May that he had had multiple job
6 changes within the past year. So that -- so that --
7 so I asked him that for two -- for both reasons.

8 Q. And did you ever obtain anymore information
9 about those multiple job changes, what they were?

10 A. (Witness indicating.)

11 Q. I actually need you to respond verbally as
12 well.

13 A. Well, I'm thinking. That was a quizzical
14 look. Let the record --

15 Q. Sure.

16 A. I'm quizzing myself. He might have told me,
17 but I don't -- I don't recall, and I didn't note it.

18 Q. On the second page of these notes from
19 December, "complains of persistent irritability,
20 sees as problematic, potentially affecting
21 occupational functioning."

22 A. Yes.

23 Q. Did you have a conversation with Mr. Whalon
24 about "occupational functioning"?

1 A. Well, I would have asked him whether he was
2 getting into fights or arguments with --

3 THE REPORTER: I'm sorry?

4 THE WITNESS: I'm sorry. Yeah, I would have
5 asked him whether he was getting into fights, fights
6 or arguments with co-workers or supervisors, and
7 it's -- I'm not -- I'm not sure quite what type of
8 work he was doing here at this point. But if he
9 was, for example, working in a store with customers,
10 you know, whether he was -- whether he was
11 quarrelsome with customers, and what he -- what he
12 said led me to believe that it might have, might
13 have been a problem or could potentially become a
14 problem, for example, like a performance review.

15 BY MR. COLOMB:

16 Q. Generally speaking, again stepping away from
17 Mr. Whalon for a moment, are these issues common for
18 individuals with bipolar disorder?

19 A. Sure.

20 Q. To your knowledge and with your
21 understanding of bipolar disorder, is there
22 anything that patients do to try to address those
23 concerns?

24 MR. SCOTT: I am going to object. Just for

1 A. I've already answered that question. No, I
2 have not.

3 Q. Do you know the cause of Mr. Whalon's
4 bipolar disorder?

5 A. I would assume that like the majority of
6 people with this condition it was familial and
7 genetic.

8 THE REPORTER: I'm sorry?

9 THE WITNESS: It was like the majority of
10 people with this condition, it was familial and
11 genetic.

12 BY MR. COLOMB:

13 Q. And as --

14 A. Just parenthetically, there are few patients
15 who develop bipolar disorder late in life associated
16 with neurological disease. So that's what's called
17 secondary mania. But that's -- so, for example, if
18 you have a brain tumor or Parkinson's or multiple
19 sclerosis or other neurological conditions, it can
20 give some patients manic symptoms.

21 Q. Do you have any reason to believe any of
22 those neurologic conditions apply to Mr. Whalon?

23 A. It would be unlikely, because as I
24 indicated, it's associated with neurological

1 disease.

2 Q. Are you aware of any other mental illness
3 apart from bipolar disorder that Mr. Whalon suffers
4 from?

5 A. If he has other mental illnesses, that has
6 not been the focus of my treatment with him and not
7 documented in this record.

8 Q. And did you ever screen him for any other
9 mental illnesses?

10 A. I presume that when I first saw him back at
11 Arbour Counseling I would have satisfied myself that
12 bipolar disorder was the correct diagnosis and not
13 some other condition. So the answer -- the answer
14 to that would be yes.

15 Q. You presume it, but you --

16 A. Well, I don't have that record.

17 Q. Don't have that available?

18 A. Don't have that record, so I can't prove it
19 to you.

20 Q. Can environmental conditions cause bipolar
21 disorder?

22 A. No.

23 Q. Can environmental conditions affect bipolar
24 disorder?

1 Q. Thank you.

2 If someone is bipolar and they are neither
3 in acute manic or acute depressive polarities, can
4 some type of life trauma cause them to go to one or
5 the other polarities?

6 A. Uh-huh. (Indicates affirmatively). Yes.
7 Yeah, for example, I know of a case that I heard of
8 from Gary Sachs, who's one of the preeminent bipolar
9 researchers at Harvard, of a woman who had
10 previously been unaffected but who had her first
11 manic episode two weeks after her husband died in
12 the World Trade Center calamity. So severe
13 psychosocial stress can trigger depression and also
14 mania.

15 But as I indicated before, there are
16 individuals with bipolar disorder that genetic
17 research from -- mostly from people at NINH, like,
18 Hussein Manji, M-a-n-j-i, who's a researcher, look
19 at a combination of protector genes and
20 susceptibility genes, so that you see even different
21 degrees of susceptibility to stress in a sibship.

22 Q. Well, let me change my question a little
23 bit. If you had someone --

24 A. That might -- that might be a more

1 scientific answer than you wanted, but --

2 Q. Well, just I want to hone in a little bit
3 more tightly on what I am trying to get your opinion
4 on.

5 A. Yeah.

6 Q. If you had a person who was previously
7 diagnosed as bipolar, --

8 A. Yeah.

9 Q. -- who is even taking medication for
10 bipolar --

11 A. Who is.

12 Q. -- but is stable and by "stable," I mean,
13 neither severely manic or they are severely
14 depressive, --

15 A. Yeah.

16 Q. -- maybe having some symptoms but those
17 symptoms are not lifestyle affecting --

18 A. Uh-huh. (Indicates affirmatively).

19 Q. -- or causing major -- I think you said
20 psychosocial issues --

21 A. Right.

22 Q. -- and then there is a significant
23 trauma, --

24 A. Yes.

1 Q. -- for example, death of a close family
2 member, --

3 A. Uh-huh. (Indicates affirmatively).

4 Q. -- loss of a long-term employment, --

5 A. Uh-huh. (Indicates affirmatively).

6 Q. -- would that type of trauma or similar
7 trauma trigger a manic or a depressive -- could it
8 trigger a manic --

9 A. It could --

10 Q. -- or depressive episode?

11 A. -- well.

12 Q. If that same person had a major life
13 stressor that triggered an exacerbation of the
14 bipolar condition, would it be likely that that
15 person would develop a hypersensitivity to that same
16 type of trauma in the future?

17 A. Well, this is conjectural but again, seems
18 plausible.

19 Q. In other words, let me ask it more
20 specifically. If that same person, let's say, it
21 was a death in the family --

22 A. Yes.

23 Q. -- and then sometime later, let's say, a
24 year or two later another family member just got

1 indicating that he was complaining of persistent
2 irritability, --

3 A. Yes.

4 Q. -- "sees as problematic, potentially
5 affecting occupational functioning"?

6 A. Yes.

7 Q. Would that type of symptomology -- how would
8 you relate that to the rating scale that you felt he
9 had at that time?

10 A. Yeah, if he was actually at the point where
11 he was about to be terminated from employment or if
12 somebody was at the point where he was so irritable
13 as to become assaultive, that's serious.

14 If it's at the point where an employee says
15 to himself "Gee, I better get things under wraps, or
16 I'm going to get in trouble at my work," that's more
17 than mild. It's appropriate for employees to know
18 when they're in trouble with their supervisors, or
19 it's appropriate for people to realize if they're
20 getting along with co-workers or arguing with
21 coworkers.

22 So from the note that I have in the record,
23 I can't tell you what the extent of his employment
24 or occupational difficulties may have been at that

1 time.

2 Q. Do you have any knowledge as to how many
3 jobs Mr. Whalon may have had within the period that
4 you treated him?

5 A. I do not.

6 Q. If, in fact, a person with Mr. Whalon's --
7 with the same diagnoses as you provided for Mr.
8 Whalon, if you had a similar patient who underwent a
9 number of rapid job changes in that period or around
10 the period of treatment and also reporting this type
11 of issue, would that alter --

12 A. Yeah.

13 Q. -- your opinion?

14 A. Yeah, if people are unable to sustain
15 competitive employment, that means they're not doing
16 well. They're more symptomatic.

17 Q. Doctor, you have given us a lot of
18 information and a lot of opinions, and I guess I am
19 just going to do this one catch-all question to you
20 because it made all the other questions that both
21 Attorney Colomb and I ask extremely shorter and
22 taking up less time. Have all the opinions that you
23 have given to us today been within a reasonable
24 degree of medical certainty?